Joint Review Committee on Education in Radiologic Technology
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www.jrcert.org

APPLICATION FOR RECOGNITION OF A
CLINICAL EDUCATION SETTING IN RADIOGRAPHY
FORM 104R

Sponsoring Institution: _____ **Program #** _____

I. CLINICAL EDUCATION SETTING FOR WHICH JRCERT RECOGNITION IS SOUGHT:

_____
Name

_____
Address

_____   _____   _____
City   State   Zip Code

CES # _____   **(To be assigned by JRCERT)**

This application must be completed for each clinical education setting.

■ Consistent with **JRCERT Policy 11.400, Procedure 11.404D**, the JRCERT considers a clinical education setting as all radiologic facilities under a single radiologic administration within the campus. A campus is defined as the buildings and grounds of a school, college, university, or hospital that are geographically contiguous and does NOT include any geographically dispersed campus of a sponsor. Separate recognition is required for each facility not meeting this definition.

■ **Enclose:**
   a. An affiliation agreement with Affiliation Agreement Criteria sheet (see page 8).
   b. **Form 102R** for each designated clinical instructor and all required attachments identified on the form.
   c. Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for the clinical education setting for which recognition is sought. For non-hospital clinical education settings that are not accredited, documentation of compliance with state and/or federal radiation safety regulations may be used as equivalent.

   NOTE: Clinical Capacity Calculation Guidelines, page 5, is used by the JRCERT to identify the student capacity of the clinical education setting. DO NOT complete page 5.

■ An application for recognition is not guaranteed. Recognition may be denied, or the capacity authorized may be less than that requested by the program.

■ **Fee** - please see the current Fee Schedule at www.jrcert.org.

II. INSTITUTIONAL/PROGRAM OFFICIALS:

__The signatures of clinical education setting officials and the director constitute a request for JRCERT recognition of the facility as a clinical education setting for the requesting program.__

A. Chief Executive Officer of Clinical Education Setting:

Name (Print)	Degree/Credentials	Title

Signature

B. Clinical Instructor(s):

Complete JRCERT **Form 102R**, and provide a **current** curriculum vitae, and documentation of **current ARRT** registration or unrestricted state license **for each individual listed**. **Duplicate and add additional Form(s) and/or page(s) as necessary.)**

- **A minimum of one clinical instructor must be identified for each clinical education setting.**
- One full-time equivalent clinical instructor must be identified for every ten (10) students involved in the competency achievement process.

Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials

Provide documentation of baccalaureate or higher degrees. (*Although not required for clinical instructors, the JRCERT database will reflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical instructor, it will be assumed that the program does not wish to have the degree noted.*) Documentation of the appropriate degree attainment from an academic institution accredited by an agency recognized by the United States Departemt of Eduction (USDE) or the Council for Higher Education Accreditaition (CHEA)

III. **CLINICAL CAPACITY -** the JRCERT will determine the clinical capacity for this facility based on documented availability of appropriate imaging equipment and qualified practitioners to assure student attainment of program learning outcomes.

   A. **Physical Resources -** List each of the imaging rooms/equipment at the facility and indicate the type. Please **check the ONE description** that best identifies the imaging equipment. **[Duplicate and add additional page(s) as necessary]**

Room /Equipment Identification (#, name, or other identifier)	Rad.	R&F	Mobile	Surgery
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
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_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

B. List the qualified practitioners (ARRT registration in radiography or equivalent) that are assigned to *a typical weekday* (Monday-Friday) who perform imaging procedures. Indicate the primary area of daily practice and include shift hours. [Duplicate and add additional page(s) if necessary.] **The student to radiography clinical staff ratio must be 1:1.**

	Rad.	R&F	Mobile	Surgery	Other *(specify)*	Shift Hours
Name of Radiographer	☐	☐	☐	☐	_____	__:__ - __:__ begin / end
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__
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_____	☐	☐	☐	☐	_____	__:__ - __:__
_____	☐	☐	☐	☐	_____	__:__ - __:__

IV. TOTAL CLINICAL CAPACITY CALCULATION GUIDELINES

THIS PAGE WILL BE COMPLETED BY THE JRCERT.

The following serve as guidelines for determining the total clinical capacity for the clinical education setting.

Type of Room	Number of Rooms/Machines	Multiplier		Subtotal
Radiography		1		
R&F Combination		1		
Mobile (1-4 Machines) = .5 student placement OR	____ = .5	N/A		
Mobile (5 or > Machines) = 1 student placement	____ = 1	N/A		
Surgery (1-4 Machines) = .5 student placement. OR	____ = .5	N/A		
Surgery (5 or > Machines) = 1 student placement.	____ = 1	N/A		
Other _____				

Recognized Program # _____ CC _____	**Total Physical Resources** Based on information from Section III,A	
Recognized Program # _____ CC _____	**Total Personnel Resources** Based on information from Section III,B	
Recognized Program # _____ CC _____	**Total Clinical Capacity (TCC)** Based on lower of two above numbers	

CC Available for Applicant Program _____

V. SITE UTILIZATION

A. **Program seeking recognition for use of this facility**. In the chart below, beginning with "Shift A", indicate the requested number of 1st year students to be assigned and the beginning and ending time of each day's rotation. If students are assigned to a second start/end time, please indicate in the "Shift B" section.   If all students are assigned to the same start and end times, skip the "Shift B" section. Repeat these steps for the 2nd year students.

		Monday	Tuesday	Wednesday	Thursday	Friday
1st Year - "Shift A"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
1st Year - "Shift B"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
2nd Year - "Shift A"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
2nd Year - "Shift B"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year -   ☐ Fall   ☐ Spring   ☐ Summer   ☐ Other   _____
                                                                                  Please indicate

2nd Year -   ☐ Fall   ☐ Spring   ☐ Summer   ☐ Other   _____
                                                                                  Please indicate

Based on the recognition of this facility, the program's total capacity will:

☐ remain the same   OR   ☐ increase by _____ students

SHARED SITE INFORMATION - if not a shared site move to page 7.

This section is to be completed by the program director of the currently recognized JRCERT accredited program.   **(If the site is currently used by more than one other program, information must be provided on separate sheets for each.)**

NOTE: If the total number of students identified in the sections below is less than the number currently on the JRCERT database for the program at this facility, the clinical capacity will be decreased to the number indicated.

B.   **Name** of program **currently recognized** for use of this facility - _____
                                                                                              Name of Program

   Recognized programs's JRCERT#:   _____

For directions to complete, see Section "A" above.

		Monday	Tuesday	Wednesday	Thursday	Friday
1st Year - "Shift A"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
1st Year - "Shift B"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
2nd Year - "Shift A"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end
2nd Year - "Shift B"	_____ # of Students	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end	__:__ - __:__ begin end

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year -   ☐ Fall   ☐ Spring   ☐ Summer   ☐ Other   _____
                                                                                  Please indicate

2nd Year -   ☐ Fall   ☐ Spring   ☐ Summer   ☐ Other   _____
                                                                                  Please indicate

Programs should use this section to document comments.

RADIOLOGY DEPARTMENTAL ADMINISTRATOR

I agree that the information provided on this form is correct.

_____   _____
Name (Print)   Title

_____
Signature

PROGRAM DIRECTOR - PROGRAM SEEKING SITE RECOGNITION

I agree that the information provided on this form is correct and that if recognition of this site is granted,
the program will abide by the usage of the site as proposed.

_____   _____
Name (Print)   Title

_____
Signature

PROGRAM DIRECTOR - PROGRAM HOLDING CURRENT SITE RECOGNITION.
To be completed ONLY if site is to be shared.
Pages 6 & 7 must be completed by ALL programs with current site recognition
(including those sites identified as inactive).

I agree that the information provided on this form is correct and that if recognition of this site is granted,
the program will abide by the utilization of the site as proposed on page 6.

Program #:
_____   _____
Name (Print)

_____
Signature

VI. AFFILIATION AGREEMENT CRITERIA:

Attach a copy of this page to the front of the signed affiliation agreement submitted.

Sponsoring Institution: _____ **Program #** _____

Clinical Education Setting Name: _____

The affiliation agreement must identify the following three (3) criteria as outlined below. Please identify where they are located by highlighting, circling, or otherwise indicating the verbiage in the body of the agreement and identifying the page and paragraph number in the space provided below.

☐   RESPONSIBILITY FOR STUDENT SUPERVISION:

     Page and Paragraph Number _____

☐   ADEQUATE NOTICE OF TERMINATION OF THE AGREEMENT:

     Page and Paragraph Number _____

     The JRCERT considers three (3) months notice of termination or assurance that students currently enrolled and assigned to the facility will be able to complete their clinical assignment at the facility.

☐   RESPONSIBILITY FOR LIABILITY:

     Page and Paragraph Number _____

NOTE: An affiliation agreement is not required for clinical education settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.